CHAPTER IV

COVERED SERVICES AND LIMITATIONS

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The Virginia Medicaid Program covers a variety of psychiatric services for eligible recipients. This chapter describes these services and the requirements for the provision of them. Contents of the chapter are organized under the following main headings:

- Inpatient Psychiatric Services
- Treatment Foster Care Case Management
- Outpatient Psychiatric Services

INPATIENT PSYCHIATRIC SERVICES (ACUTE HOSPITAL AND RESIDENTIAL)

Acute Care Hospitals

Psychiatric acute inpatient services are available to recipients of all ages in psychiatric units of general acute care hospitals. For recipients 21 years of age and older, coverage is provided for days that are medically necessary and is limited to a maximum of 21 days. This 21-day limit applies to the first eligible 21 days of hospitalization for the same diagnosis within a 60-day period. The 60-day period begins with the first approved day of a hospital admission. Only 21 total days will be covered for the same or similar diagnosis, whether incurred in one or more hospital stays or in the same or multiple hospitals, during the 60-day period. For recipients receiving treatment who are under the age of 21, inpatient psychiatric services are covered beyond the 21-day limit as long as criteria are met. Residential treatment is available in psychiatric units of acute hospitals for recipients under age 21. For Comprehensive Services Act children, a Certificate of Need for Admission is required as specified in "Independent Team Certification" in this chapter. Refer to the *Hospital Manual*, issued by DMAS, for specific requirements for acute care facilities.

Freestanding Hospitals - Over Age 65 Category

Services for recipients ages 22 to 64 are not reimbursable by Medicaid in an institution for mental diseases (IMD). "Institution for mental diseases" means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for the mentally retarded is not an institution for mental diseases.

Certification of Need for Care in Freestanding Hospitals

A physician must certify for each recipient that inpatient services in a freestanding psychiatric hospital are needed. The certification must be made at the time of admission or, if an individual applies for assistance while in a freestanding psychiatric hospital, before

the Medicaid agency authorizes payment.

A physician, or a physician assistant or nurse practitioner acting within the scope of practice and under the supervision of a physician, must recertify for each recipient that inpatient psychiatric services are needed. This recertification must be made at least every 60 days.

Medical, Psychiatric, and Social Evaluations and Admission Review-Freestanding Hospitals

Prior to admission to a freestanding psychiatric hospital, or before authorization for payment, the attending physician or staff physician must make a medical evaluation of each recipient's need for care in the hospital. In addition, appropriate professional personnel must make a psychiatric and social evaluation. Each medical evaluation must include:

1. Diagnoses;
2. Summary of present medical findings;
3. Medical history;
4. Mental and physical functional capacity;
5. Prognosis; and
6. A recommendation by a physician concerning admission to the freestanding psychiatric hospital or continued care in the hospital for individuals who apply for Medicaid while in the freestanding psychiatric hospital.

Plan of Care-Freestanding Hospitals

Prior to admission to a freestanding psychiatric facility, or before authorization for payment, the attending physician or staff physician must establish a written Plan of Care for each recipient. The Plan of Care must include:

1. Diagnoses, symptoms, complaints, and complications indicating the need for admission;
2. A description of the functional level of the recipient;
3. Objectives;
4. Any orders for: medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the recipient;
5. Plans for continuing care, including review and modification to the plan of care; and
6. Plans for discharge.

The attending or staff physician and other personnel involved in the recipient's care must review each plan of care at least every 90 days.

FREESTANDING (ACUTE CARE) HOSPITAL AND RESIDENTIAL TREATMENT FACILITY UNDER AGE 21

Medicaid will pay for inpatient psychiatric services in a freestanding hospital and in residential treatment facilities for individuals under age 21 whose need for services has been identified through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program.

The criteria for Medicaid reimbursement for freestanding inpatient psychiatric services has been established based on the federal regulations in 42 CFR § 441, Subpart D, and §§ 16.1-335 and §§ 37.1-67.1 of the Code of Virginia. Any Medicaid-eligible individual seeking admission to a freestanding psychiatric hospital or residential treatment facility must be certified as requiring inpatient services in order for the psychiatric facility to receive Medicaid reimbursement for the admission.

Independent Team Certification

Federal regulations (42 CFR § 441.152) require certification by an independent team that inpatient psychiatric services are needed for any recipient applying for Medicaid-reimbursed admission to a freestanding inpatient psychiatric facility or residential treatment facility. The certification must be current, within 30 days prior to placement. The independent team must include mental health professionals including a physician. The independent team will be from the Community Services Board (CSB) serving the area in which the individual resides (or the area in which the individual is located). Prescreenings are not reimbursable by Medicaid. For residential treatment for Comprehensive Services Act children (CSA), the independent team will be the local Family Assessment and Planning Team (FAPT) or a collaborative, multidisciplinary team approved by the State Executive Council consistent with § 2.1-753-755 of the Code of Virginia. The majority of the team and the physician must sign the certification. Team members must have competence in the diagnosis and treatment of mental illness (preferably in child psychiatry) and have knowledge of the individual's situation (42 CFR § 441.153). The justification for certification must be child-specific. The team must indicate what less restrictive community resources have been accessed and failed to meet the individual's needs or why community resources will not meet the individual's current treatment needs.

A Medicaid-reimbursed admission to an acute care facility, a freestanding psychiatric facility, or a residential treatment facility can only occur if the independent team can certify that:

1. Ambulatory care resources (all available modalities of treatment less restrictive than inpatient treatment) available in the community do not meet the treatment needs of the recipient;

2. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and

3. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

The certification of need for hospital admission and for non-CSA residential placements must be documented on the Pre-Admission Screening Report (DMH 224) or similar form, which must be signed and dated, by the screener and the physician. (See "Exhibits" at the end of this chapter for a sample of this form). It is not sufficient to merely check on the DMH 224 that each of the above certification of need criteria has been met. The team must indicate what less restrictive community resources have been accessed and failed to meet the individual's needs or why community resources will not meet the individual's current treatment needs. For emergency acute care admissions, Federal regulation (42CFR 441.153) allows up to 14 days for the team responsible for the plan of care in the facility to certify the admission. The certification must meet the criteria listed above. The team must meet the criteria for the treatment team (42CFR 441.156) listed in this chapter in the section on the Comprehensive Individual Plan of Care.

An emergency admission is defined as a psychiatric hospitalization that is required because the individual is a danger to himself or others or when the individual is incapable of developmentally appropriate self-care due to a mental health problem. The admission follows a marked reduction in the individual's psychiatric, adaptive, or behavioral functioning or an extreme increase in personal distress.

If a child resided in a psychiatric residential facility and requires an acute psychiatric admission and is returning to a psychiatric residential facility, a new certificate of need is required. The certification may be completed by the acute facility physician and treatment team as long as the physician meets the criteria noted in federal regulations 42 CFR 441.152-153.

A physician, or a physician assistant, or, nurse practitioner acting within the scope of practice and under the supervision of a physician, must recertify for each recipient that inpatient psychiatric services are needed. This must be done at least every 60 days.

Initial Plan of Care

In accordance with federal requirements (42 CFR § 441.156), the team must establish a written plan of care at admission, which must be signed and dated by the attending or staff physician, indicating the physician has examined the child and approved the plan. The plan must include:

- The diagnosis, symptoms, and complaints indicating the need for admission;
- A description of the functional level of the recipient;
- Recipient-specific treatment objectives with short- and long-term goals;
- Orders for medications, treatments, therapies, etc.;
- Plans for continuing care, including review of the Plan of Care;

- Prognosis; and
- Discharge plans.

Any available medical, social, and psychiatric evaluations must be submitted with the certification of need to the freestanding inpatient psychiatric hospital. The Certification of Need must be completed and dated prior to admission and the request for authorization.

For residential admission, the Child and Adolescent Functional Assessment Scale (CAFAS) or the Preschool and Early Childhood Functional Assessment Scale (PECFAS)[1] must also be completed and current within 90 days. For non-CSA children, a CAFAS is not required.

Development of the Comprehensive Individual Plan of Care for Residential Treatment

The Comprehensive Individual Plan of Care (CIPOC) is a written plan developed for each recipient. The Comprehensive Individual Plan of Care must be completed no later than 14 days after admission for residential treatment; the CIPOC must be completed before requesting continued stay. The Plan of Care must:

- Be based on diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the recipient's situation and reflects the need for inpatient care;
- Be developed by a team of professionals in consultation with the recipient, and the recipient's parents, legal guardians, or others in whose care the recipient will be released after discharge;
- State recipient-specific treatment objectives with measurable short- and long-term goals with target dates for achievement;
- Prescribe an integrated program of therapies, activities, and experiences designed to the meet the objectives; and
- Include post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to achieve the recipient's discharge from inpatient status at the earliest possible time and ensure continuity of care with the recipient's family, school, and community upon discharge.

The diagnostic evaluation upon which the plan of care is to be developed may include medical, social, and psychological evaluations that were completed prior to the individual's admission to the psychiatric facility and submitted with the Certification of Need.

[1] These instruments are available from Kay Hodges, Ph.D, 2140 Old Earhart Road, Ann Arbor, MI 48105 (734) 769-9725

The medical and psychological evaluations of the need for inpatient psychiatric care must include:

a. Diagnoses;
b. Summary of present medical findings;
c. Medical/psychiatric history;
d. Mental and physical functional capacity; and
e. Prognosis.

The social evaluation must include the psychosocial assessment and an evaluation of home plans and available community resources.

The provider is expected to aggressively treat individuals with a full range of therapies and educational and recreational activities. For residential treatment, all of the services must be provided at the facility as part of the therapeutic milieu. This includes medication management, psychotherapy, and an appropriate school program. Medicaid reimbursement for inpatient psychiatric services will not be available for inpatient stays during which active treatment, according to the goals and objectives related to the individual's diagnostic needs, is not provided or the individual no longer requires inpatient treatment due to his or her psychiatric condition. The recipient is allowed a maximum of 18 days annually of therapeutic leave while in residential care. The purpose of the leave days is to facilitate discharge from residential treatment. The therapeutic purpose, goals, and response to the leave must be documented.

It is critical that the initial Plan of Care and the Comprehensive Individual Plan of Care be developed by a team of professionals in consultation with the recipient and the recipient's parents, legal guardians, or others in whose care the recipient will be released after discharge. In accordance with federal requirements (42 CFR § 441.156), the team must include one of the following:

- A Board-eligible or Board-certified psychiatrist;
- A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or
- A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been certified by the state or by the state psychological association.

The team must also include one of the following:

- A psychiatric social worker.
- A registered nurse with specialized training or one year's experience in treating mentally ill individuals.
- An occupational therapist who is licensed, if required by the state, and who has

specialized training or one year of experience in treating mentally ill individuals.

- A psychologist who has a master's degree in clinical psychology or who has been certified by the state or by the state psychological association.

For residential treatment, the Comprehensive Individual Plan of Care must be reviewed every 30 days.

PREAUTHORIZATION FOR ALL INPATIENT (ACUTE AND RESIDENTIAL) PSYCHIATRIC SERVICES

DMAS utilizes the services of an outside contractor to preauthorize all Inpatient Psychiatric Services. The selected contractor is WVMI.

Inpatient Acute Psychiatric Services

Planned, elective, and acute admissions must be telephonically preauthorized prior to the date of admission. Emergency or urgent admissions must be telephonically preauthorized within one workday after the admission. When calling WVMI for inpatient hospitalization, the following information must be provided:

- Recipient name;
- Recipient's Medicaid identification number;
- Facility's provider number;
- Name of the referring team and the date the screening was done;
- Admitting physician's name;
- Admitting diagnosis;
- Psychiatric condition; and
- Plan of Care.

The numbers to phone for authorization are:

804-648-3159	Richmond Area
800-299-9864	All Other Areas

For hospital admissions, WVMI will apply the Inpatient Psychiatric Criteria to the medical information provided. If criteria for admission are met, an initial length of stay will be assigned not to exceed seven days.

Prior to the expiration of the initial assigned length of stay, if the recipient requires continued inpatient psychiatric services, the health care provider must contact WVMI to initiate the concurrent review process. For inpatient hospitalization, the health care provider must be able to provide WVMI with the recipient's name and Medicaid identification number/preauthorization number and must be prepared to discuss the medical indications and Plan of Care for continued hospitalization. WVMI will apply the Inpatient Psychiatric Criteria to the medical information provided and will assign an additional length of stay if criteria are met for continued inpatient stay. Concurrent review will

continue in the same manner until the recipient is discharged.

All inquiries regarding the status of an inpatient psychiatric preauthorization request or DMAS' policy on inpatient psychiatric services must be directed to the Provider HELPLINE at:

(804)-786-6273 Richmond area
1-800-552-8627 All other areas

Residential Treatment

Residential treatment admissions must be preauthorized within 24 hours of admission or on the next business day after admission. WVMI will respond within three (3) business days of receipt of the information.

All preauthorization requests must be submitted by fax. The WVMI preauthorization request forms are available on the DMAS website at www.dmas.virginia.gov. The facility must contact WVMI and request authorization at the time of admission. Retroactive requests for authorizations will not be approved with the exception of retroactive eligibility. When retroactive eligibility is obtained, the request for authorization should be submitted no later than 30 days from the date notified of Medicaid eligibility.

When faxing requests for residential treatment, the following information must be provided:

- Recipient name
- Recipient Medicaid identification number
- Facility provider number
- CAFAS or PECFAS current within 90 days of admission (for CSA children) (If the child is under age four (4) or over age 17, complete as much as possible and specify where the tool is not appropriate for the child's age).
- Verification of the Certification of Need
- DSM IV diagnosis, all five axes
- Description of behavior seven days prior to admission
- Description of alternative placement tried and outcomes
- Child's functional level and clinical stability
- Level of family support
- Initial Plan of Care
- Treatment goals and objectives
- Treatment interventions provided
- Discharge planning, including an estimated length of stay

For non-CSA residential placements only – Preauthorization may be submitted to WVMI seven (7) days prior to the admission date. All of the above information is required, and all criteria for authorization remain the same. WVMI will respond within three (3) business

days.

Prior to placement, the locality is responsible for checking the Medicaid eligibility file to determine that the correct responsible city or county is designated. The locality noted on the eligibility file (managed by the locality's eligibility office) will be credited on the monthly CSA report provided to the Office of Comprehensive Services for any Medicaid-paid claims for residential placements. If there is any question, the locality should check with their county DSS eligibility office.

The numbers for facsimile preauthorization (WVMI) are:

804-648-6880	Richmond Area
888-243-2770	All Other Areas

For residential treatment, if the criteria for admission are met, an initial length of stay will be assigned but will not exceed 31 days. A preauthorization number will also be provided for billing purposes.

For residential treatment, the provider must fax their continued stay material to WVMI before the end of the current authorization but no earlier than the 25th day of the current authorization. The provider must submit to WVMI the requested information, including the most recent CAFAS or PECFAS (for CSA placement only). WVMI will apply the residential treatment services criteria to the information provided and will assign an additional length of stay if criteria are met for continued residential stay.

ACUTE INPATIENT HOSPITAL PSYCHIATRIC SERVICES CRITERIA

WVMI utilizes the following medical necessity criteria in conjunction with the *State Plan for Medical Assistance* for all inpatient psychiatric hospital authorizations on and after February 18, 1997.

A. Definitions:

- "Acute" means within 24 hours.
- "Active Treatment" means implementation of a professionally developed and supervised individual Plan of Care.
- "Ambulatory Care" means services provided in the recipient's home community, which may include: outpatient therapy, crisis intervention, psychosocial rehabilitation, therapeutic day treatment, intensive in-home services, or case management.
- "On Admission" means within four hours.
- "Recent Onset" means within one week.

- "Severe Psychiatric Disorder" means clinical manifestation, symptoms, or complications which are so severe as to preclude diagnostic assessment and appropriate treatment in a less intensive treatment setting and which require 24-hour nursing/medical assessment, intervention, or monitoring.

B. Severity of Illness

1. Care and treatment shall be provided in the least restrictive treatment environment possible. The following shall be reviewed by WVMI to determine whether or not a lower level of care or ambulatory care was considered and found inappropriate to meet the needs of the recipient.

   a. Recipient is currently receiving ambulatory care and not responding to treatment; or,

   b. Recipient's identified condition is escalating; or,

   c. Recipient's condition is of an emergency nature with recent onset, or is a reoccurrence of a previous acute psychotic condition; or,

   d. Recipient's condition requires monitoring of newly prescribed drugs with a high rate of complication or adverse reactions; or,

   e. Recipient's condition requires monitoring for toxic effects from therapeutic psychotropic drugs.

2. Individuals admitted for inpatient hospital level of care must be diagnosed with a severe psychiatric disorder. There must be documented evidence of recent onset of one of the following conditions:

   a. Current suicide attempt or ideation. Behavior reflecting a suicide attempt or suicidal intent with a plan. Degree of intent, availability of method, and immediacy of plan should support the decision to admit; or,

   b. Current assaultive, self-mutilative, or destructive behavior. Immediate danger to self or others is apparent. This behavior must require intensive psychiatric medical management and nursing interventions on a 24-hour basis; or,

   c. Current hallucinations (visual or auditory) or bizarre or delusional behavior. Patient exhibits reality testing deficits or hypomanic behavior severe enough to present danger to self or others; or,

   d. Inability to perform activities of daily living because of severe psychiatric symptoms. This may include psychomotor retardation, severe depression, social withdrawal, agitation, autistic or catatonic behavior; or,

   e. Disorientation or memory impairment to the degree of endangering

welfare; or,

f. Loss of body control, total body rigidity, immobility, seizures (withdrawal or toxic), or obsessive-compulsive behavior, which cannot be controlled.

3. The following disorders do not justify inpatient hospital admission unless the other severity of illness criteria in B (1) and B (2) above or medical criteria are also met.

a. Organic brain syndrome
b. Hyperactivity
c. Attention deficit disorders
d. Dyslexia
e. Behavior or personality disorders
f. Eating disorders
g. Alcohol and/or drug abuse
h. Mental retardation
i. Alzheimer's disease

4. DMAS will not reimburse for any services that do not meet the severity of illness criteria as listed in B (1) and B (2) above. Some examples of non-reimbursable services include, but are not limited to:

- Remedial education
- Evaluation for educational placement or long-term placement
- Day care
- Behavioral modification
- Psychological testing for educational diagnosis, school, or institutional admission or placement
- Alcohol or drug abuse therapy
- Residential treatment
- Partial hospitalization programs

C. Intensity of treatment required. To meet criteria for continued stay, the intensity of treatment must relate to the severity of illness with the goal of improving or preventing regression of the recipient's condition so services will no longer be needed.

1. The active treatment plan must relate to the admission diagnosis and reflect:

a. At least one of the following:

(1) Physical restraint/seclusion/isolation; or,
(2) Suicidal/homicidal precautions; or,
(3) Escape precautions; or,
(4) Drug therapy (any route) requiring specific close medical supervision; and,

b. All of the following:

(1) A licensed professional (psychiatrist, clinical psychologist, psychiatric clinical nurse specialist, licensed clinical social worker, or licensed professional counselor) provides individual therapy five out of seven days; and

(2) A minimum of 21 hours, excluding individual treatment, school attendance, and family therapy, of appropriate treatment interventions are provided each week (i.e., group, with specific topics focused to patient needs; socialization, educational, behavioral interventions; play/art/music therapy; occupational therapy; and physical therapy). These modalities of treatment may be a part of the total treatment plan but must not be the major treatment modality; and,

(3) The family, caretaker, or case manager is involved on an ongoing basis with treatment planning and participates in family therapy at a minimum of once per week unless documentation demonstrates, based on the treatment plan, why it is not feasible and addresses alternative involvement in therapy; and,

(4) Active treatment and discharge planning begin at admission.

2. Medical record documentation must include:

a. Stabilization or improvement of presenting symptoms with progress notes reflecting positive or negative reactions to treatment on a daily basis; and,

b. Continued necessity for skilled observation, structured intervention, and support that can only be provided at the hospital level of care; and,

c. Concurrent documentation of therapies as provided, including individual treatment, according to the treatment plan, specific to hours and number of days provided, topics covered, and response to the therapy; and,

d. If the minimum treatment outlined in C.1.b.(2) above is not provided, document why the individual was unable to participate.

3. Therapeutic passes:

a. One therapeutic day pass is allowed if the goals of the day pass are documented prior to the day pass and, if on return, the effect of the day pass is documented. If the first day pass is determined not to have reached the goals and indications exist, a second day pass may be

permitted. Day passes which are not a part of the written plan of treatment or documented as to expected and experienced therapeutic effect are not permitted.

b. Overnight passes are not permitted.

D. Expected outcome/discharge. Continued hospital level of care is not appropriate and will not be covered when one or more of the following exist:

1. The stabilization of presenting symptoms with demonstrated ability to perform activities of daily living appropriate for age and to function appropriately within hospital environment; or,

2. The required treatment can be provided in a less restrictive environment; or,

3. The type or dosage of major psychotropic medication has been unchanged for the last five days or there is medical documentation to support no variation in drug therapy; or,

4. There has been no documented evidence of a change in treatment plan when the recipient has not responded in a seven-day period; or,

5. The recipient refuses to cooperate with the treatment plan.

INPATIENT RESIDENTIAL TREATMENT SERVICES CRITERIA

WVMI will apply the Residential Treatment Services criteria.

Definitions:

- "Active Treatment" means implementation of a professionally developed and supervised individual plan of care.
- "Ambulatory Care" means services provided in the recipient's home community, which may include outpatient therapy, crisis intervention, psychosocial rehabilitation, therapeutic day treatment, intensive in-home services, or case management.
- "On Admission" means within twenty-four hours.
- "Recent Onset" means within seven days.
- "Residential inpatient care" means a 24-hour per day specialized form of highly organized, intensive, and planned therapeutic interventions which shall be utilized to treat severe mental, emotional, and behavioral disorders. All services must be provided at the facility as part of the therapeutic milieu.
- "Licensed Mental Health Professional" includes a psychiatrist, licensed clinical psychologist, licensed clinical social worker, psychiatric clinical nurse specialist, or a

licensed professional counselor.

The admission and documentation criteria are:

A. Severity of Illness: Both 1 and 2 must be met:

1. Care and treatment shall be provided in the least restrictive treatment environment possible. The following shall be reviewed by DMAS to determine whether a lower level of care or ambulatory care was considered and found inappropriate to meet the needs of the recipient. *One or more must be present:*

   a. The recipient is currently receiving community based care with evidence of failure at a less restrictive level of care;

   b. The recipient's identified condition is escalating; or

   c. The recipient's condition is a reoccurrence of a previous acute psychiatric condition.

2. Individuals admitted for inpatient residential level of care must have been diagnosed with a psychiatric disorder. There must be documented evidence of recent onset of *one or more* of the following conditions:

   a. The recipient is unable to function in a less restrictive environment evidenced by dysfunction in interpersonal, family, education, or development;

   b. The recipient has had a history of acute psychiatric episodes and currently is not making progress or cooperating with the treatment plan in a less restrictive level of care;

   c. There are recent increased threats of harm or aggression towards self or others;

   d. The recipient is unable to function safely in the community without jeopardizing the safety of self or others;

   e. There has been recent stabilization of symptoms during a psychiatric hospitalization but the recipient needs a structured 24-hour therapeutic environment to prevent regression, solidify gains, and or further resolve complex psychiatric symptoms; or

   f. Recent outpatient treatment has failed. Ambulatory care resources available in the community do not meet treatment needs because the individual suffers one or more complicating concurrent medical disorders which the family is not effectively addressing (e.g., conduct disorder with seizures, depression with insulin dependent diabetes mellitus).

B. Intensity of treatment required. To meet criteria for admission, the intensity of treatment must relate to the severity of illness with the goal of improving the recipient's condition so services will no longer be needed, or preventing progression to an acute stage.

1. The active treatment plan must relate to the admission diagnosis and reflect *all of the following*:

   a. A licensed professional (psychiatrist, clinical psychologist, licensed clinical social worker, licensed professional counselors, or clinical nurse specialist-psychiatric with education and experience with children and adolescents) provides individual therapy three out of seven days;

   b. A minimum of 21 distinct sessions (excluding individual treatment, school attendance, and family therapy) of appropriate treatment interventions are provided each week (i.e., group therapy, with specific topics focused to patient needs; insight-oriented and/or behavior modifying). Play/art/music therapy, occupational therapy, and physical therapy may be included; however, these modalities of treatment must not be the major treatment modality;

   c. The family, guardian, caretaker, or case manager is involved on an ongoing basis with treatment planning. The family, guardian, or caretaker participates in family therapy at a minimum of twice monthly except when the family dysfunction is a reason for admission, then family therapy should be at least once per week. At least one of these family therapy sessions must be face-to-face each month. Family therapy is limited to one unit per day, regardless of the number of participants or family members in the session. If the family, guardian, or caretaker is not involved as required, documentation must demonstrate why it is not feasible or not in the best interest of the child for the family to participate. Alternatives for treatment due to the lack of a family's involvement should be addressed (telephonic therapy is a non-reimbursable service) and the discharge plan revised to address the lack of family involvement; and

   d. Active treatment and comprehensive discharge planning for aftercare placement and treatment must begin at admission.

2. Medical record documentation must include *all of the following:*

   a. Stabilization or improvement of presenting symptoms with progress notes reflecting positive or negative reactions to treatment on a daily basis;

   b. Continued need for skilled observation, structured intervention, and support that can only be provided at the residential level of care;

c. Concurrent documentation of therapies as provided. Progress notes for each session must describe how the activities of the session relate to the recipient-specific goals, the frequency and duration of the session, the level of participation in treatment, the type of session (group, individual), and the plan for the next session. Notes must contain the dated signatures of the providers. Examples of some types of non-billable sessions include educational, socialization, recreational, current events, nursing, grooming and substance abuse; and

d. If the minimum treatment outlined in B.1 above is not provided, document why the individual was unable to participate.

Residential Treatment Continuing Stay Criteria

A. Severity of Illness: *All of the following must be present*:

1. Continued complex presenting symptoms or emergence of new symptoms that are amenable to treatment in a psychiatric residential facility;

2. Recipient involved and cooperative with treatment;

3. Continued impairment in level of functioning;

4. Continues to require restrictive setting;

5. Ambulatory care resources available in the community will not meet the treatment needs; and

6. Continued services can reasonably be expected to improve the condition or prevent further regression.

B. Intensity of Treatment*: All of the following services must be provided in order to meet continuing stay criteria*:

1. The multidisciplinary recipient-specific treatment plan must be updated every thirty (30) days. It must include recipient-specific long- and short-term goals, measurable objectives, and interventions with time frames for achievement; the treatment plan must be revised to address goals achieved, unresolved problems, and any new problems which have arisen;

2. Services must continue to require the supervision of a physician; and

3. Integrated program of therapies including milieu therapy, activities, and experiences designed to meet the treatment objectives; active provision of interventions including individual, group, and, if applicable, family therapy as required in B.1 (a-d) above.

Expected outcome/discharge criteria. Continued residential level of care is not appropriate and will not be covered when *one or more of the following exist (severity of illness and intensity of treatment should be reviewed):*

A. The stabilization of presenting symptoms with demonstrated ability to perform activities of daily living appropriate for age and to function appropriately within residential environment and a community setting;

B. The required treatment can be provided in a less restrictive environment;

C. There is documented evidence, from the use of day and an overnight pass, that the recipient has been able to function safely and satisfactorily within the community;

D. There has been no documented evidence of a change in treatment plan when the recipient has not responded for a 20-day period; or

E. The recipient refuses to cooperate with the treatment plan.

Special Notes

1. The following disorders do not justify residential treatment facility admission unless the other severity of illness criteria or medical necessity criteria are also met:

    a. Hyperactivity
    b. Attention deficit disorders
    c. Dyslexia
    d. Behavior or personality disorders
    e. Eating disorders
    f. Alcohol and or drug abuse
    g. Mental retardation

2. DMAS will not reimburse for any services that do not meet the severity of illness criteria. Some examples of non-reimbursable services include:

    a. Remedial education
    b. Evaluation for educational placement or long-term placement
    c. Day care
    d. Psychological testing for educational diagnosis, school or institutional admission and/or placement
    e. Alcohol or drug abuse therapy
    f. Partial hospitalization programs

3. Therapeutic passes:

    a. Therapeutic passes are permitted if the goals of the pass are part of the master treatment plan. The goals of a particular visit must be

documented prior to granting the pass and, on return, its effects must be documented. Passes should begin with short lengths of time (e.g., 2-4 hours) and progress to a day pass. The function of the pass is to assess the recipient's ability to function outside the structured environment and to function appropriately within the family and community.

b. Days away from the facility may occur only after the completion and documentation of successful day passes and as a part of the discharge plan. Outcomes of the therapeutic leave must be documented. No more than 18 days of therapeutic leave annually are allowed. Days of leave are counted from the date of admission to Medicaid covered service.

4. If a child requires acute, inpatient medical treatment (non-psychiatric), is on runaway status or goes to detention, the facility is required to send WVMI a fax notification of the stay. The fax must include the child's name and Medicaid number, the authorization number, the name of the hospital with admission and discharge dates and the reason for the admission. If the stay away from the facility is for more than seven (7) days, the provider must notify WVMI, and this will be processed as a discharge. Any subsequent residential treatment would require preauthorization as a new admission. If a child requires acute psychiatric admission, any subsequent residential treatment would require preauthorization as a new admission.

   None of the days away from the residential facility for acute medical, acute psychiatric, runaway, or detention are billable under a residential authorization.

5. Residential treatment services may not be billed concurrently with any Community Mental Health Rehabilitative Services, with two exceptions: Intensive In-Home Services for Children and Adolescents (H2021) and Case Management (T1007 HE). These two services may be billed for up to seven days, immediately upon admission to a residential facility or immediately prior to discharge from a residential facility, to transition the child from home to the residential setting or from the residential setting to home, as applicable.

Reconsiderations and Appeals

For inpatient hospitalization, if an admission or continued stay is denied by the WVMI review analyst, and the provider disagrees with the decision, the provider must follow a two-step telephonic reconsideration process. Immediately upon notification of denial, the provider must request higher level of review; first to the WVMI Supervisor, and second to DMAS Medical Support for physician review.

For residential treatment, if an initial or continued stay review is denied by the WVMI review analyst and the provider disagrees with the decision, the provider must follow a facsimile reconsideration process. The reconsideration request must be submitted within 10 business days of notification of the adverse decision to the WVMI Behavioral Health

Supervisor. For residential treatment, subsequent continued stay reviews must continue to be submitted to WVMI, even though a reconsideration or appeal has been submitted for prior dates of service.

Following the appropriate reconsideration process, the denial of preauthorization for services not yet rendered may be appealed in writing by the Medicaid recipient within 30 days of the written notification of denial. If the preauthorization denial is for a service that has already been rendered, and the issue is whether DMAS will reimburse the provider for the services already provided, the provider may appeal the denial in writing within 30 days of the written notification of denial. Send all written appeals to:

Director, Appeals Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

TREATMENT FOSTER CARE CASE MANAGEMENT

Children under age 21 in Treatment Foster Care (TFC) who are Seriously Emotionally Disturbed (SED) or children with behavioral disorders, who, in the absence of such programs, would be at risk for placement into more restrictive residential settings, are eligible for Treatment Foster Care Case Management.

TFC Case Management

Treatment Foster Care Case Management means an activity, including casework, which assists Medicaid eligibles in gaining and coordinating access to necessary care and services appropriate to their needs. Casework means both direct treatment with a child or several children, and intervention in the situation on the child's behalf. The objectives of casework include: meeting the child's needs, helping the child deal with the problem with which he or she is confronted, strengthening the child's capacity to function productively, lessening distress, and enhancing opportunities and capacities for fulfillment.

Treatment Foster Care Case Management is directed toward children or youth with a behavioral disorder or emotional disturbance referred to treatment foster care by the Family Assessment and Planning Team of the Comprehensive Services Act (CSA) for Youth and Families or a collaborative, multidisciplinary team approved by the State Executive Council consistent with § 2.1-755 of the Code of Virginia. "Child" or "youth" means any Medicaid-eligible child under age 21 years of age who is otherwise eligible for CSA services. Family Assessment and Planning Teams (FAPT) are multidisciplinary teams of professionals established by each locality in accordance with § 2.1-754 of the Code of Virginia to assess the needs of children referred to the team. The FAPT shall develop individual service plans for youths and families reviewed by the team. The FAPT shall refer the children needing Treatment Foster Care Case Management to a qualified participating case manager.

Treatment Foster Care Case Management is a component of treatment foster care through which a case manager or caseworker provides treatment planning and treatment services,

monitors the treatment plan, and links the child to other community resources as necessary to address the special identified needs of the child. Services to the children shall be delivered primarily by treatment foster parents who are trained, supervised, and supported by professional child-placing agency staff. TFC Case Management focuses on a continuity of services that is goal-directed and results-oriented, and it emphasizes permanency planning for the child in care. Services shall not include room and board. The following activities are considered covered services related to TFC Case Management services:

1. Placement activities, which may include, but are not restricted to, care planning, placement monitoring, and discharge planning;

2. Case management and casework services; and

3. Supervision of foster parents to evaluate the effectiveness of the child's plan of treatment.

Duties of a Treatment Foster Care Case Manager are to:

- Perform a periodic assessment to determine the child's needs for psychosocial, nutritional, medical, and educational services;

- Develop individualized treatment and service plans to describe the services and resources needed to meet the needs of the child and to help access those services and resources;

- Coordinate services and service planning with other agencies and providers involved with the child;

- Refer the child to services and supports specified in the individualized treatment and service plans;

- Follow up and monitor ongoing progress in each case to ensure services are delivered by continually evaluating and reviewing each child's Plan of Care;

- Support the child's relationship with the foster family, including visits to the treatment parents to address issues, resolve problems, and build relationships.

- Provide casework to meet the child's needs, help him or her deal with the problem he or she is confronting, strengthen his or her capacity to function productively, lessen his or her distress, and enhance his or her opportunities and capacities for fulfillment. Casework means both direct treatment with an individual or several individuals and intervention in the situation on the child's behalf.

If a child is temporarily out of the home, services must be limited to seven (7) days. The provider must notify WVMI, at the time of the next review, of the child’s absence from the home and of the child’s return to the home. Documentation of active case management services is required to bill for days the child is out of the home in the following situations:

1. Placement for inpatient services, in cooperation with the facility to assist in discharge planning for transition back to the home;

2. Runaway – if the case manager is actively involved in finding the child to be returned to the home; and

3. Detention – refer to the Chapter II discussion on "inmate" and verify Medicaid eligibility.

Caseload Size: The treatment foster care case manager shall have a maximum of 12 children in his or her caseload for a full-time professional staff person. The caseload shall be adjusted downward if:

1. The caseworker's job responsibilities exceed those listed in the agency's job description for a caseworker, as determined by the supervisor; or

2. The difficulty of the client population served requires more intensive supervision and training of the treatment foster parents.

3. Exception: A caseworker may have a maximum caseload of 15 children as long as no more than 10 of the children are in treatment foster care and the above criteria for adjusting the caseload downward do not apply.

4. There shall be a maximum of six children in the caseload for a beginning trainee that may be increased to nine by the end of the first year and 12 by the end of the second year.

5. There shall be a maximum of three children in a caseload for a student intern, if any work in the agency.

Treatment Teams in Treatment Foster Care

The Treatment Foster Care Case Management provider shall assure that a professional staff person provides leadership to the treatment team that includes managing team decision-making regarding the care and treatment of the child and services to the child's family. The provider must provide information and training to the treatment team members as necessary. The provider must involve the child and the child's family in treatment team meetings, plans, and decisions and keep them informed of the child's progress whenever possible. Treatment team members shall consult as often as necessary, but no less often than quarterly.

Treatment and Service Plans in Treatment Foster Care

The Treatment Foster Care Case Management provider shall prepare and implement an individualized comprehensive treatment and service plan for each child in its care. When available, the parents shall be consulted unless parental rights have been terminated. If

parents cannot be consulted, the agency shall document the reason in the child's record.

When the Treatment Foster Care Case management provider holds custody of the child, a service plan shall be filed with the court within 60 days after the agency receives custody unless the court grants an additional 60 days or the child is returned home or placed for adoption within 60 days. Providers with legal custody of the child shall follow the requirements of §§ 63.1-281 and 63.1-282 of the Code of Virginia.

The permanency planning goals and the requirements and procedures in the Department of Social Services' *Service Programs Manual*, Volume VII, Section III, Chapter B, "Preparing the Initial Service Plan" may be consulted.

Comprehensive Treatment and Service Plan in Treatment Foster Care

The case manager and other designated child-placing agency staff shall develop and implement for each child in care an individualized comprehensive treatment and service plan within the first 45 days of placement that shall include:

1. A comprehensive assessment of the child's emotional, behavioral, educational, and medical needs;

2. The treatment goals and objectives, including the child's specific problems, behaviors and skills to be addressed, the criteria for achievement, and target dates for each goal and objective;

3. The Treatment Foster Care Case Management provider's program of therapies, activities, and services, including the specific methods of program of therapies, activities, and services, including the specific methods of intervention and strategies designed to meet the above goals and objectives, and describing how the provider is working with related community resources to provide a continuity of care;

4. The permanency planning goals and objectives, services to be provided for their achievement, and plans for reunification of the child with his or her family, where appropriate;

5. The target date for discharge from the program;

6. For children age 16 and over, a description of the programs and services that will help the child transition from foster care to independent living; and

7. The plan shall be signed and dated by the case manager. It shall indicate all members of the treatment team who participated in its development.

The case manager shall include and work with the child, the custodial agency, the treatment foster parents, and the parents, where appropriate, in the development of the treatment and service plan, and a copy shall be provided to the custodial agency. A copy shall be provided to the treatment foster parents as long as confidential information about

the child's birth family is not revealed. A copy shall be provided to the parents, if appropriate, as long as confidential information about the treatment foster parents is not revealed. If any of these parties do not participate in the development of the treatment and service plan, the case manager shall document the reasons in the child's record.

The case manager shall provide supervision, training, support, and guidance to foster families in implementing the treatment and service plan for the child. The case manager shall arrange for and encourage contact and visitation between the foster child, his or her family, and others as specified in the treatment and service plan.

Progress Reports and Ongoing Services Plans in Treatment Foster Care

The case manager shall complete written progress reports beginning 90 days after the date of the child's placement and every 90 days thereafter. The progress report shall specify the time period covered and include:

1. Progress on the child's specific problems and behaviors and any changes in the methods of intervention and strategies to be implemented, including;

    a. A description of the treatment goals and objectives met, goals and objectives to be continued or added, the criteria for achievement, and target dates for each goal and objectives;

    b. A description of the therapies, activities, and services provided during the previous 90 days toward the treatment goals and objectives; and

    c. Any changes needed for the next 90 days.

2. Services provided during the last 90 days toward the permanency planning goals, including plans for reunification of the child and family or placement with relatives, any changes in these goals, and services to be provided during the next 90 days, including:

    a. The child's assessment of his or her progress and his or her description of services needed, where appropriate;

    b. Contacts between the child and the child’s family, where appropriate;

    c. Medical needs, specifying medical treatment provided and still needed and medications provided;

    d. An update to the discharge plans including the projected discharge date; and

    e. A description of the programs and services provided to children 16 and older to help the child transition from foster care to independent living, where appropriate.

Annually, the progress report shall address the above requirements, as well as evaluate and

update the comprehensive treatment and service plan for the upcoming year. The case manager shall date and sign each progress note.

The case manager shall include each child who has the ability to understand in the preparation of the child's treatment and service plans and progress reports or document the reasons this was not possible. The child's comments shall be recorded in the report. The case manager shall include and work with the child, the treatment foster parents, the custodial agency, and the parents, where appropriate, in the development of the progress report. A copy shall be provided to the placing agency worker and, if appropriate, to the treatment foster parents.

Contacts with the Child in Treatment Foster Care

1. There shall be face-to-face contact between the case manager and the child, based upon the child's treatment and service plan and as often as necessary to ensure that the child is receiving safe and effective services.

2. Face-to-face contacts shall be no less than twice a month, one of which shall be in the foster home. One of the contacts shall include the child and at least one treatment foster parent and shall assess the relationship between the child and the treatment foster parents.

3. The contacts shall assess the child's progress, provide training and guidance to the treatment foster parents, monitor service delivery, and allow the child to communicate concerns.

4. A description of all contacts shall be documented in the narrative.

5. Children who are able to communicate shall be interviewed privately at least once a month.

6. The case manager shall record all medications prescribed for each child and all reported side effects or adverse reactions.

Unless specifically prohibited by a court or the custodial agency, foster children shall have access to regular contact with their families as described in the treatment and service plan. The case manager shall work actively to support and enhance child-family relationships and work directly with the child's family toward reunification as specified in the treatment and service plan.

Professional Clinical or Consultative Services in Treatment Foster Care

In consultation with the custodial agency, the case manager or caseworker shall provide or arrange for a child to receive psychiatric, psychological, and other clinical services as recommended or identified in the treatment service plan.

Record Documentation in Treatment Foster Care

Entries in Case Records: All entries shall be dated and shall identify the individual who performed the service. If a treatment foster care case management provider has offices in more than one location, the record shall identify the office that provided the service. Each child's record shall contain documentation that verifies the services rendered for billing.

Narratives in the child's record: Narratives shall be in chronological order and current within 30 days. Narratives shall include areas specified in these regulations and shall cover: treatment and services provided; all contacts related to the child; visitation between the child and the child's family; and other significant events. Each contact with the child, his or her family, foster family, or other individual in the course of providing case management services must be documented in the child's record.

Plans of Care: Copies of all assessments and plans of care must be filed in the child's case record.

Preauthorization for Treatment Foster Care Case Management

TFC case management must be preauthorized by DMAS or its designee. DMAS utilizes the services of an outside contractor, WVMI. Documentation must be sent to WVMI within ten days of admission except in cases of retroactive eligibility. WVMI will respond to the preauthorization request within ten business days. To obtain preauthorization, the following documentation must be submitted:

A. A completed CAFAS or PECFAS, current within 90 days – If the child is less than four (4) years of age or over age 17, complete as much as possible and specify that the tool is not appropriate for the child's age;

B. All of the following documentation:

1. DSM IV Diagnosis
2. Initial Plan of Care (completed within two [2] weeks of placement)
3. A description of the child's immediate behavior prior to admission
4. A description of alternative placements tried or explored
5. The child's functional level
6. Clinical stability;
7. The level of family support available; and
8. Discharge planning; and

C. One of the following:

1. Written documentation that the CPMT has approved the admission to treatment foster care; or
2. Certification by the FAPT that TFC case management is medically necessary.

D. Multidisciplinary Team Assessment (FAPT) which must include:

1. Assessment of the child's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities;

2. Assessment of the potential for reunification of the child's family;
3. Set treatment objectives;
4. Prescribe therapeutic modalities to achieve the plan's objectives.

Assessment

Each child must be assessed by a Family Assessment and Planning Team (FAPT) or a collaborative, multidisciplinary team approved by the State Executive Council consistent with § 2.1-755 of the Code of Virginia. The team must assess the child's immediate and long-range therapeutic needs, developmental priorities, personal strengths and liabilities, the potential for reunification with the recipient's family, set treatment objectives, and prescribe therapeutic modalities to achieve the plan's objectives. The assessment must be signed and dated by a majority of the FAPT members.

Medical Necessity Criteria

The child must have a documented moderate to severe impairment and moderate to severe risk factors as recorded on a state designated uniform assessment instrument. The child's condition must meet one of the three levels described below.

a. **Level I:** Moderate impairment with one or more of the following moderate risk factors as documented on the CAFAS:

   (1) Needs intensive supervision to prevent harmful consequences;
   (2) Moderate/frequent disruptive or non-compliant behaviors in home setting which increase the risk to self or others;
   (3) Needs assistance of trained professionals as caregivers.

b. **Level II:** The child must display a significant impairment with problems with authority, impulsivity, and caregiver issues as documented on the CAFAS. For example, the child must:

   (1) Be unable to handle the emotional demands of family living;
   (2) Need 24-hour immediate response to crisis behaviors; or
   growth.

c. **Level III:** The child must display a significant impairment with severe risk factors as documented on the CAFAS. The child must demonstrate risk behaviors that create significant risk of harm to self or others.

If the medical necessity is met, an initial length of stay will be assigned. Prior to the expiration of the initial assigned length of stay, if the recipient requires continued treatment foster care case management beyond the initial length of stay, the health care provider must contact the WVMI review staff to initiate the concurrent review process. The review analyst will apply the medical necessity criteria to the information provided and will assign an additional length of stay if criteria are met for continued care. Concurrent review will continue in the same manner until the recipient is discharged.

Preauthorization for Continued Stay of Treatment Foster Care Case Management

All of the following documentation is required:

1. Current CAFAS (required to be done a minimum of every 90 days);
2. Current Comprehensive Treatment and Service Plan;
3. Progress reports since last review; and
4. Progress update that supports medical necessity criteria (to cover time since the last 90-day progress report).

WVMI may request additional information.

Retrospective reviews are performed when a provider is notified of a recipient's retroactive eligibility for Virginia Medicaid coverage.

Reconsiderations and Appeals

If an admission or continued stay is denied by the WVMI review analyst and the provider disagrees with the decision, the provider must follow the reconsideration process. The provider must submit a request in writing to the WVMI Behavioral Health supervisor requesting a reconsideration. This request must be submitted within 30 days of the notification of the denial and submitted to:

WVMI
Behavioral Health Supervisor
6802 Paragon Place – Suite 410
Richmond, VA 23230

After completion of the reconsideration process, the denial of preauthorization for services not yet rendered may be appealed in writing by the Medicaid recipient within 30 days of written notification of denial. If the preauthorization denial is for a service that has already been rendered, and the issue is whether DMAS will reimburse the provider for the service already provided, the provider may appeal the denial in writing within 30 days of the written notification of denial. Send all written appeals to:

Director, Appeals Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

OUTPATIENT PSYCHIATRIC SERVICES

Outpatient psychiatric services are provided in a practitioner's office or a mental health clinic. Services shall be medically prescribed treatment, which is documented in an active written treatment plan designed and signed and dated by a Licensed Mental Health Provider (LMHP).

Criteria for Participation

In order for a recipient to qualify to receive outpatient psychiatric services, the recipient must meet ALL of the following criteria:

A. Requires treatment in order to sustain behavioral or emotional gains or to restore cognitive functional levels, which have been impaired;

B. Exhibits deficits in peer relations, deficits in dealing with authority, hyperactivity, poor impulse control, clinical depression, or demonstrates other dysfunctional symptoms having an adverse impact on attention and concentration, the ability to learn, or the ability to participate in employment, educational, or social activities;

C. Is at risk for developing or requires treatment for maladaptive coping strategies; and

D. Presents a reduction in individual adaptive and coping mechanism or demonstrates extreme increase in personal distress.

Specific Service Limits

The following services are limited to no more than three visits in a seven-day period when performed as an outpatient service:

- Individual medical psychotherapy coverage is limited to once per day.
- Medical evaluation and management are included in the individual psychotherapy codes; evaluation and management services codes should not be used.
- Group medical psychotherapy coverage is limited to once per day. Services for sensory stimulation, recreational activities, art classes, excursions, or eating together are not included as group therapy sessions. There is a maximum of 10 individuals per group session.
- Family medical psychotherapy is limited to once per day.
- Multiple-family group medical psychotherapy is a non-covered service.
- Medical hypnotherapy; environmental intervention, interpretation of examinations, procedures, and data; and the preparation of reports remain non-covered services.

- Psychological and neuropsychological testing are allowed when done for purposes other than educational diagnosis, school admission, evaluation of an individual with mental retardation prior to admission to a nursing facility, or any placement issue. Medical records must document the medical necessity for these tests. DMAS allows one per six-month period and up to four hours of units. Should the testing exceed the limits of frequency or units, the provider must provide the documentation with the bill as to the medical necessity for the testing and a list of the specific tests conducted.

- Separate payment will be allowed for the attending physician and the anesthesiologist involved in electroconvulsive therapy.

Non-Covered Psychiatric Services

The following services are non-covered services:

- Broken appointments;
- Remedial education;
- Day care;
- Psychological testing done for purposes of educational diagnosis or school admission or placement;
- Rehabilitative alcoholism and drug abuse therapy;
- Occupational therapy;
- Teaching "grooming" skills, monitoring activities of daily living, bibliotherapy, reminiscence therapy, or social interaction are not considered psychotherapy and remain non-covered.
- Telephone consultations;
- Mail order prescriptions; and
- Substance abuse services.

Preauthorization

If the first year of treatment began prior to July 1, 2003, outpatient psychiatric services are limited to 26 sessions without preauthorization, with the possibility of an additional 26 sessions when preauthorized.

Effective July 1, 2003, outpatient psychiatric services are limited to 5 sessions in the first year of treatment with one possible extension of 47 sessions, when preauthorized, during the first year of treatment. These initial 5 sessions must be used within one year of the first date of service (anniversary date) and cannot be carried over into subsequent years. For

individuals 21 years of age or older, there is the possibility of an additional 26 sessions in subsequent years when preauthorized. For individuals under 21 years of age, all outpatient psychiatric services rendered in subsequent treatment years must be preauthorized and medically necessary.

It is the responsibility of the provider of psychiatric treatment to ascertain from any recipient being accepted for care whether he or she has received psychiatric treatment reimbursed by DMAS and to what extent his or her allocation may have been used.

The five-session restriction does not apply to the psychiatric diagnostic interview examination (CPT Code 90801). However, only one such procedure per recipient may be billed if medically necessary within a 12-month period.

To check whether authorization is required for additional psychiatric services, you may call the Automated Voice Response System "Medicall" at 1-800-772-9996 or contact the Medicaid HelpLine at 1-800-552-8627. The claims history file contains information on paid claims. If a claim has not been paid, the number of available sessions may be overstated. Claims for services, which exceed the sessions available to the individual without authorization, will be denied. DMAS is not responsible for claims denied because the service limit has been reached.

If the provider does not request an extension prior to the expiration of the effective service limits (26 or 5 as applicable), authorization can begin no earlier than the date the preauthorization request is received by the DMAS Preauthorization Unit. DMAS will not provide retrospective authorization, unless it is in the case of retroactive eligibility. Any faxed requests received after the close of business will be credited to the next business day.

Submission of Extension Requests

In order to request preauthorization, the provider may fax the DMAS-412, Request for Extension of Psychiatric Services, and DMAS-351, or Preauthorization Request Fax Sheet to DMAS. Providers may also request preauthorization telephonically by calling DMAS. When calling for preauthorization, the provider must be prepared to provide the same information as is found on the DMAS-412 and DMAS-351. Requests received by telephone will be pended until DMAS receives the completed forms. Pend responses and reconsideration requests may also be submitted via fax or telephone.

DMAS can be reached at:

Phone Numbers: (804) 225-3536

Fax Numbers: (804) 225-2603
(866) 248-8796

DMAS accepts changes and deletions for preauthorizations by fax. To submit changes by fax, send a completed DMAS-361, signed and dated by a qualified professional and additional information. The additional information must include the tracking number to be changed, the CPT codes affected, the total number of units needed, the dates requested, and

an explanation of why the change is needed. A new, updated DMAS 412 must be submitted if crossing an anniversary date, a change in the type of therapy, or additional sessions are requested. To request a deletion, send a completed DMAS 412 and include the tracking number to be deleted. When a deletion is made, all units and dates for the tracking number are deleted. If any of the units and dates have changed, submit a change. To request either a change or delete by telephone, the provider must have the same information available to complete the request.

Reconsiderations and Appeals

If services are denied by the DMAS analyst and the psychiatric service provider wants to request reconsideration of the denial, the provider must follow the reconsideration process. If a telephone request is denied, the provider may request either telephonic or written reconsideration from the DMAS Payment Processing Unit Supervisor within 30 days of the date of the denial. The DMAS Payment Processing Unit Supervisor has the option of requiring written reconsideration of a telephone preauthorization request. For a written reconsideration request, the provider must submit a letter to the DMAS Prior Authorization and Utilization Management Supervisor requesting reconsideration within 30 days of the notice of denial, to:

DMAS
Prior Authorization and Utilization Management Supervisor
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

For outpatient psychiatric services, if the Prior Authorization and Utilization Management Supervisor upholds the denial, the provider may request physician review. After completion of the reconsideration process, the denial of preauthorization for services not yet rendered may be appealed in writing by the Medicaid recipient within 30 days of the written notification of denial. If the preauthorization denial is for a service that has already been rendered, the provider may appeal the adverse decision in writing within 30 days of the written notification of denial of the reconsideration. Written appeals must be addressed to:

Appeals Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

The provider may not bill the recipient for covered services that have been provided and subsequently denied by DMAS.

EXHIBITS

TABLE OF CONTENTS

UNIFORM PREADMISSION SCREENING FORM

This form is to be completed by a qualified professional designated by the Community Services Board to determine if an individual meets criteria for civil commitment or is in need of voluntary or involuntary admission to a psychiatric hospital. Please refer to the Uniform Preadmission Evaluation Procedures and the Continuity of Care Guidelines.

DATE _____ **TIME (From** _____ **To**_____**)** **DISPOSITION: VOL TDO OTHER CASE NO.**_____

I. PERSONAL DATA

Name: _____ Age: _____ Date of Birth: _____

Address: _____
(Street) (City or County) (State) (Zip Code)

Phone: ( )_____ Marital Status: _____ SSN: _____

Physical description: _____ _____ _____ _____ _____ _____
(Sex) (Race) (Height) (Weight) (Hair Color) (Eye Color)

Emergency Contact: _____ Relationship to Client: _____

Address: _____
(Street) (City or County) (State) (Zip Code)

Phone: Home ( )_____ Work ( )_____

Monthly Income: $_____ SSI/SSDI: $_____ Payee: _____ Veteran: Y N ?

Insurance: Y N ? _____ _____
(Name of Insurance Company) (Group/Plan Number)

Medicaid: Y N ? #_____ Medicare: Y N ? #_____

(If under 18) School Division: _____ School Attending: _____ Grade: _____ Special Education: Y N

CSB of Origin: _____ Contacted: Y N N/A **PRAIS Code**

Name of CSB Staff Contacted:_____ Phone ( )_____

II. LEGAL DATA

Pending legal charges: Y N - If yes, complete the following information: Nature of charges (if known): _____

Date of hearing (if known): _____ Court of Jurisdiction: _____ Client serving a sentence: Y N ?
NGRI Conditional Release: Y N ? Probation/Parole: Y N ? Contact:_____

III. COLLATERAL SOURCES OF INFORMATION		Yes	No	N/A
Client Record	(Agency)			
Individual Requesting Evaluation	(Name & Relationship to Patient)			
Primary Therapist	(Name)			
Other	(Name & Relationship to Patient)			

IV. FOR LOCAL USE

2

V. MEDICAL

Primary Care Provider: _____ Phone ( )_____

Medical History & Current Medical Problems/Symptoms:_____

_____

_____

Medication: Current prescribed psychotropic and other medications (include dosage, schedule, etc. if known)

	Name	**Dose**	**Schedule**	**Length of Time Taken**
1.				
2.				
3.				
4.				
5.				

Recent medication changes: Y N ? (If yes, explain) _____

Allergies or adverse side effects to medications: Y N ? (If yes, explain)_____

_____

Has client complied with recommended medication and treatment plans? Y N ? (If no, describe nature of non-compliance)_____

_____

VI. MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT: Service providers (e.g., Eastern State Hospital, CSB, CSB contractual agency, private provider, etc.) and services and/or treatment provided.

	Service Provider/Facility	**Services/Treatment Provided**	**Date Last Seen**
1.			
2.			
3.			
4.			

VII. PRESENT SITUATION (Include information such as precipitating events, stressors and variation, if any, from baseline level of functioning. _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

3

VIII. MENTAL STATUS EXAM (Circle all that apply)

Appearance:	WNL	Poor unkempt	poor hygiene		bizarre	tense	rigid	
Behavior/Motor Disturbance:	WNL	agitation	guarded	tremor	manic	impulse control	psychomotor retardation	
Orientation:	WNL	disoriented:	time	place	person	situation		
Speech:	WNL	pressured	slowed	soft/loud	impoverished	slurred	other	
Mood:	WNL	depressed	angry/hostile	euphoric	anxious	anhedonic	withdrawn	
Range of Affect:	WNL	constricted	flat	labile	inappropriate			
Thought Content:	WNL	delusions	grandiose	ideas of reference	paranoid	obsessions	phobias	
Thought Process:	WNL	loose associations	flight of ideas	circumstantial	blocking	tangential	perseverative	
Perception/ Sensorium:	WNL	hallucinations:	auditory	visual	olfactory	tactile	illusions	
Memory:	WNL	impaired:	recent	remote	immediate			
Appetite:	WNL	poor	Weight: loss	gain	Appetite: increased	decreased		
Sleep:	WNL	hypersomnia	onset problem	maintenance problem				
Insight:	WNL	blaming	little	none				

Estimated Intellectual/Functional Capacity: above average | average | below average | diagnosed MR

Explain clinically significant findings: _____

_____

_____

_____

_____

_____

_____

IX. SUBSTANCE ABUSE ASSESSMENT (Check if no current use _____)

	Hx	Past 24 hrs	Blood Present	Drug of Choice	Frequent (Past 30 days)	Method	Last used
Tremors			N/A	**Primary:**			
Seizures			N/A	**Secondary:**			
DT's			N/A	**Comments/Test Results:**			
Vomiting			Y N				
Diarrhea			Y N				

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X. RISK ASSESSMENT

Suicide Potential: Hx of ___Attempts Current __Attempt __Ideation ___Intent Plan: ____Vague Plan: ____Defined ____Means Active ____Psychosis Current ___Substance Abuse

Homicide Potential: Hx of ___Assault Assault or __ Attempt __ Ideation ___Intent Plan: ___ Vague Plan: ____Defined ____Means Active ___ Psychosis Current ___Substance Abuse

Specify: _____

_____

_____

XI. DIAGNOSIS: DSM IV (P=Provisional, H=Historical) **GAF:** _____

Axis I: _____

Axis II: _____

XII. FINDINGS (Circle)

X **Is / is not** mentally ill and/or abusing substances.
X **Is / is not** an imminent danger to self or others.
X **Is / is not** able to care for self.
X **Is / is not** capable of consenting to voluntary treatment/hospitalization.
X **Is / is not** willing to be treated voluntarily.
X There **are / are not** less restrictive community alternatives to serve this person.

_____

XIII. DISPOSITION RECOMMENDATION (Check appropriate "PreDetention" box if evaluation is conducted prior to the issuance of a T.D.O. Check appropriate "PreHearing" box if evaluation is conducted after the issuance of a T.D.O. but prior to the commitment hearing.)		
PreDetention		**PreHearing**
	Client does not meet criteria for hospitalization and/or commitment and should be encouraged to participate in community based services.	
Not Applicable	Involuntary commitment to outpatient services because client meets criteria for involuntary commitment, community alternatives are available for involuntary commitment, and client is incapable or unwilling to consent to voluntary treatment.	
	Voluntary hospitalization because client does not meet criteria for involuntary commitment, has the capacity to consent to voluntary treatment, requires treatment in a hospital and has requested said treatment.	
Not Applicable	Voluntary hospitalization because the client requires treatment in a hospital, has the capacity to consent to treatment, and if, in the presence of the special justice and under court order, the client agrees to a voluntary period of treatment up to 72 hours and to give 48 hours notice to leave in lieu of involuntary commitment for up to 180 days.	
	Involuntary hospitalization because client meets criteria for involuntary hospitalization and is incapable of consenting to voluntary treatment.	
	Involuntary hospitalization because client meets criteria for involuntary hospitalization, is capable of consenting to voluntary treatment, but is unwilling to be treated voluntarily.	

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XIV. FINDINGS OF HEARING EVALUATOR (*To be completed if "PreHearing" Disposition Recommendation differs from "PreDetention" Disposition Recommendation.*):

XV. TREATMENT AND DISCHARGE PLANNING (*to be completed only if inpatient treatment is recommended).*

Individuals who can assist in treatment and discharge planning (i.e., family, discharge planner, therapist, family physician, etc.)

Name	**Phone No.**	**Relationship to Client**
1.		
2.		
3.		

Inpatient treatment goals: _____

Services to be considered in planning for discharge:

____medication management	____substance abuse services	____housing /residential services
____case management	____financial support/entitlement	____medical/dental/nutritional services
____outpatient (ind., fam., group)	____adult or child protective services	____legal assistance/advocacy
____psychosocial/day treatment	____transportation	____nursing home care

____other_____

_____ _____

Signature of Prescreener | Prescreening Agency/Board

_____ _____

Print Name Here | Date

_____

Signature of Hearing Evaluator

_____ _____

Print Name Here | Date

DMAS REQUEST – EXTENSION OF PSYCHIATRIC TREATMENT

Recipient Name: _____ Age: _____ Medicaid ID#: _____

Date of First Service: _____ Diagnosis: _____

Provider Name:_____ Provider ID#: _____

Specific Symptoms & Behaviors of Present Psychiatric Illness:

Plan of Treatment: Individual Psychotherapy ____Sessions per month

 Group Therapy ____Sessions per month

 Family Therapy ____Sessions per month

Participants: _____

 Medications (Include name of med, dose and frequency)

Goals of Treatment (Include separate goals for each therapy received):

Prognosis:

Previous Treatment Received:

Specific Progress Toward Treatment Goals:

Client Specific Reason for Extension:

Signature:_____ Title: _____ Date: _____

For Fax Submissions to DMAS:
Local (804) 225-2603
Toll- Free (866) 248-8796

DMAS 412, 1/03

Instructions for the DMAS 412
Request for Extension of Psychiatric Services

The DMAS 412 must be fully completed in order for a preauthorization to be conducted.

Recipient Name:	Enter the full name of the recipient receiving services.
Age:	Enter the age of the recipient receiving services.
Medicaid ID #:	Enter the recipient's twelve digit Medicaid ID number.
Date of First Service:	Enter the date that you began treating this recipient.
Diagnosis:	Enter the current diagnosis for which the recipient is receiving services.
Provider Name:	Enter the name of the provider of services.
Provider ID #:	Enter the seven-digit Medicaid provider ID number.
Symptoms & Behaviors:	Enter specific symptoms and behaviors resulting in the recipient's need for receiving services.
Plan:	Indicate which services the recipient is receiving and the frequency. Indicate any community resources or other services that the recipient has utilized or is utilizing. Indicate participating members of the family in family therapy.
Dates Requested:	Enter the time frame for which you are requesting preauthorization. Enter month, day and year.
Visits Requested:	Enter the number of visits for which you are requesting preauthorization during the requested time frame.
Goals:	Enter specific goals of treatment. Enter the expectations for the recipient achieving these goals and at what level. Goals should be different for each therapy the recipient receives.
Prognosis:	Indicate the forecast of the likely outcome of treatment.
Previous Treatment:	Describe any treatment that has been tried before.
Progress:	Indicate progress the recipient has made towards the goals.
Reason for Extension:	Indicate why the extension of services is needed. Be specific for each recipient.
Signature:	The provider of services must sign the DMAS-412, indicate their title and indicate the date of signature (month, day and year).